

OMB Burden Disclosure Statement

Public reporting burden for this collection of information is estimated to average 120 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Information Management, Program Management Group, Records Management Team, HR-424-GTN, Paperwork Reduction Project (1910-0300), U. S. Department of Energy, 1000 Independence Avenue, S.W., Washington, DC 20585, and the Office of Management and Budget (OMB), Paperwork Reduction project (1910-0300), Washington, DC 20503.

**U.S. Department of Energy
INDIVIDUAL ACCIDENT/INCIDENT REPORT
Official Use Only - Privacy Act**

PRIVACY ACT STATEMENT

Pursuant to 5 USC 552a(e), enacted into law by section 3 of the Privacy Act of 1974 (Public Law 93-579), the following statement is furnished to individuals who supply information to the Department of Energy (DOE) on this form. This information is maintained in a system of records, designated as DOE-38 and described in Federal Register 14309 (April 2, 1982).

1. **AUTHORITY.** Atomic Energy Act of 1954, as amended. Pursuant to 5 USC 301; Department of Energy Organization Act, including authorities referenced in Title III of the Department of Energy Organization Act; Federal Tort Claims Act, 28 U.S.C. 2671-2680; Military Personnel and Civilian Employees Claims Act, 31 U.S.C. 240-243; Executive Order 12009.
2. **PRINCIPAL PURPOSE(S).** This information is used by the DOE in its evaluation of occurrences involving worker injury/illness, property damage, and vehicle damage associated with activities and in exercising its statutory responsibility to monitor and regulate the safety and health practices at DOE and DOE contractor facilities. These data permit a meaningful comparison of both the current and long-term safety and health experience among DOE facilities.
3. **ROUTINE USES.** The information may be used to provide data to other Federal and State agencies involved in monitoring and/or evaluating occupational injuries and illnesses. The information may also be disclosed to appropriate Federal, State, or local agencies in the event the information indicates a violation or potential violation of law and in the course of an administrative or judicial proceeding.
4. **WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION.** DOE and DOE contractors must complete this form in compliance with the guidelines outline in DOE O 231 and DOE M 231.1-1. The social security number is used to assure that DOE has an accurate identifier not subject to the coincidences of similar names or birth dates among the large number of persons on whom the data are maintained.

5. SYSTEM MANAGER(S) AND ADDRESS

Deputy Assistant Secretary for
Worker Health and Safety, EH-5
U.S. Department of Energy
19901 Germantown Road
Germantown, MD 20874-1290

**GENERAL INSTRUCTIONS FOR COMPLETING
DOE F 5484.3**

This form is to be used to record all accidents/ incidents reportable under DOE O 231 and DOE M 231.1-1. Each accident should be investigated to the degree necessary to fully complete each section of the form. Mail completed forms to the CAIRS Input Coordinator:

SCIENTECH, Inc.,
1690 International Way, Idaho Falls, ID 83402
Attention: CAIRS Input Coordinator.

GENERAL INFORMATION

1. Indicate the name of the reporting organization (DOE Office, DOE Contractor, or subcontractor) where the accident took place. Enter the 7-character identification number that has been assigned to the specific reporting organization.
2. Enter the case number. All cases for a given reporting organization are to be numbered in sequence, regardless of accident/incident type, with the first two digits representing the year (i.e., the tenth accident of 1995 is numbered 95010). Check the box marked "Revision," if applicable. (NOTE: Revised data will overwrite previously reported data that have been entered into the database.).
3. Enter multiple-case number, if applicable. Multiple-case accident/incidents are those that result in more than one recordable instance of injury, property or vehicle damage, or combination there (e.g., two or more injured persons, two or more damaged vehicles, or any combination of injury/property/vehicle cases). Report each case that resulted from a single accident/incident on a separate DOE F 5484.3, with an identical multiple case accident number to show relationship to the common accident/incident. For example, if the first multiple-case accident of the year resulted in two

S&H001 – Subcontractor Safety, Health and Radiological Requirements
Attachment 4 – DOE Individual Accident/Incident Report, DOE Form 5484.3

individual employees being injured in a one-car rollover, each case would be reported on a separate DOE F 5484.3 and assigned sequential case numbers (e.g., 95005 and 95006). The vehicle damage, if reportable, would be shown on a third form and assigned case number 95007. However, the same multiple case number (e.g., 01 for the first multiple case of the year) should be entered on line 3 of each of the three forms. Additional multiple accidents in the year should be numbered sequentially (e.g., 01, 02, 03).

4. Check the box that best characterizes the type of accident/incident. Include in vehicle type all transportation accident; (e.g., highway vehicle, aircraft, marine, and railroad).

5. Indicate the investigation Type: A, B, or C). The Non-recordable box is used when a previously reported case has been revised to non-recordable status, (e.g., found to be less than the reportable amount for dollars lost).

6. Enter the Department or Division. This input field is available for structuring subgroups within a reporting organization.

7. Enter date of accident/incident.

8. Enter time of accident in Military time.

9. Check the appropriate box to indicate where the accident occurred.

10. Check the appropriate box to indicate if accident/incident occurred on employer's premises.

11. Enter the specific location of the accident (e.g., laboratory, test area 10, office area 615, street address).

EMPLOYEE INFORMATION

12. Check appropriate box (i.e., injured or ill employee or operator of equipment/vehicle).

13. Enter the name and address of employee or operator.

14. Enter Social Security number of employee or operator.

15. Enter date of birth of employee or operator.

16. Check appropriate box (i.e., "Female" or "Male") to indicate gender of employee or operator.

17. Enter generic job title of employee or operator (e.g., engineer, welder, security guard).

18. Enter time employee began work in Military time.

19. Enter date of hire.

20. Check the appropriate box for length of job/equipment experience.

INJURY/ILLNESS INFORMATION

If injury/illness was checked in Number 4, complete this section; if not, proceed to Number 27.

21. Check appropriate box. Refer to the form OSHA No. 200 (Injury code 10 or Illness Codes 21 through 29) to obtain applicable code.

22. Enter number of workdays lost due to accident/incident. If employee has not returned to work, enter your best estimate of expected days away from work. If necessary, submit a revision if estimated loss of workdays is incorrect.

23. Enter number of restricted workdays resulting from accident/incident. If employee is still on restricted status, enter best estimate of expected restricted days. Submit a revision if estimated restricted workdays is incorrect.

24. Check appropriate box to indicate whether the employee has returned to work with no further workdays lost or restrictions anticipated.

25. Check appropriate box to indicate if employee was transferred or terminated because of disability related to injury/illness.

26. Check appropriate box to indicate whether accident/incident resulted in death. If "yes", enter date of death.

PROPERTY/VEHICLE DAMAGE

27. If "Property Damage" was checked in Number 4, check the appropriate box to the property loss type.

28. If "Vehicle" was checked in Number 4, check the appropriate box to indicate type of vehicle involved in accident/incident.

29. Check appropriate box for each question concerning seat belts.

30. Check appropriate box to indicate if accident/incident involved a recordable injury.

31. Enter the total dollar amount (rounded to nearest dollar) of accident/incident damage loss on first line. On following lines, separate the loss between DOE and non-DOE property or vehicle damage, entering the dollar amounts rounded to the nearest dollar.

32. Record amount of claim against DOE for damages to non-DOE vehicles/property, if applicable, and the amount actually paid by DOE when available. Enter the amount of dollar loss, if any, to vehicle/property that should be reimbursable to DOE; also enter the amount actually paid to DOE, if and when available. Do not delay the report. If necessary, submit a revision to report actual amounts paid after the case is settled.

33. Check appropriate box to indicate whether dollar amounts are final.

S&H001 – Subcontractor Safety, Health and Radiological Requirements
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34. Give the generic or brand name, model. Identification should be adequate to alert other of potential hazards associated with a specific model.

35. Check appropriate box to indicate if the equipment design or defect contributed to the accident cause or severity.

NARRATIVE GUIDE

36. Explain what activity or assignment was in progress at the time of the accident (Examples: 1. Routine housekeeping duties were being performed. 2. Employee was involved in a routine security inspection. 3. No activity was in the facility due to extended holiday weekend).

37. Describe the accident sequentially, beginning with the initiating event, and followed by secondary and tertiary events. End with the nature and extent of injury/damage. Name any object or substance and tell how they were included. Provide the name and address of the health care provider and (if hospitalized as a result of the accident) indicate the name and address of the hospital. Examples: 1) Employee was pulling utility cart that was loaded with wastepaper from office area to hallway. Wheel of utility cart caught against door casing. Bags of heavy wastepaper that were in cart fell to end of cart. Cart tipped over onto foot of employee. Right foot was crushed between utility cart and door casing, resulting in severe contusion to right foot of employee. 2) No employee activity. HVAC system malfunctioned during long weekend. Upper floor of office building became excessively hot and triggered the automatic sprinkler system. Upper office area and contents were damaged by water. Extensive cleanup required. 3) Employee was driving patrol car from guard station to research facility. Patrol car struck icy section of road. Employee lost control of vehicle, which skidded across road into concrete abutment on side of road. Accident resulted in damage to right fender, tire, headlight, and grill.

38. Conditions – State the conditions that existed at the time of the accident (the specific control factors that were or may have been the direct or immediate cause or causes of the accident). Examples: 1) Wheel of utility cart was worn and would not roll properly. Utility cart was overloaded with wastepaper. 2) Thermostatic control of HVAC system has been improperly installed during recent replacement. 3) Road was covered with icy spots. Weather was foggy.

Actions—Enter the actions on the part of the employees that contributed to the occurrence of the accident/incident Examples: 1) Employee overloaded the utility cart with wastepaper. 2) Facility maintenance had not inspected the newly installed thermostatic control. 3) Employee exceeded safe speed on icy road, and was inattentive to hazard.

Factors influencing a or b – List the influencing factors or underlying causes, either conditions or actions or both, that contributed to the accident/incident. Examples: 1) Employee had not been instructed in overloading hazards. 2) No existing supervisory review over craft-assigned repairs. 3) Employee had not been trained in driving under winter conditions. Company has no driver training program.

39. Actions taken – Describe the actions taken to prevent recurrence of accident/incident. Examples: 1) Wheels of utility cart were replaced with larger size wheels. All carts were inspected for safe operation. Maintenance employees were instructed in overloading hazards. 2) Thermostatic control was inspected and found free of defects; it was then properly rewired. 3) All security personnel were instructed at the safety training meeting on driving under hazardous conditions.

Actions recommended – Describe corrective actions that are planned by line management and require time for implementation. Examples: 1) Provide human factors review of utility carts and other equipment purchases. 2) Management is to review maintenance procedures and inspection process. 3) Driver training program will be implemented).

Provide the implementation date for recommended corrective action.

40. Enter the name of the person who completed the form who can be contacted for follow-up, the date the form was prepared, the telephone number, and the investigator's official position.

41. Enter the name and telephone number of the cognizant supervisor. This should be the individual who, by his signature, concurs in and assures corrective action implementation.

42. Enter the name and telephone number of the person to contact with questions regarding the information contained in the report, if different from number 40.

S&H001 – Subcontractor Safety, Health and Radiological Requirements
Attachment 4 – DOE Individual Accident/Incident Report, DOE Form 5484.3

DOE F 5484.3 (05-98) All Other Editions Are Obsolete		U.S. Department of Energy INDIVIDUAL ACCIDENT/INCIDENT REPORT Official Use Only - Privacy Act		OMB Control No. 1910-0300	
General Information					
1.	Organization Name _____ Organization Code _____	6.	Department, Division, or I.D. Code _____		
2.	Case Number _____ Revision? <input type="checkbox"/> Yes	7.	Date of Occurrence _____ Month Day Year (YYYY)		
3.	Did accident involve more than one reporting organization? <input type="checkbox"/> Yes <input type="checkbox"/> No	8.	Time of Event _____ (Military)		
4.	Accident Type <input type="checkbox"/> Injury/Illness <input type="checkbox"/> Vehicle <input type="checkbox"/> Property Damage <input type="checkbox"/> Other _____	9.	Accident Occurred <input type="checkbox"/> Indoors <input type="checkbox"/> Outdoors		
		10.	On Employer's Premise? <input type="checkbox"/> Yes <input type="checkbox"/> No		
5.	Investigation Type <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	11.	Specific Location _____		
Employee Information					
12.	Check one: <input type="checkbox"/> Injured/Illness Employee <input type="checkbox"/> Operator of Equipment/Vehicle <input type="checkbox"/> Not Applicable	17.	Occupation _____ _____		
13.	Name _____ Home Address _____ _____	18.	Time Employee Began Work _____ (Military)		
14.	Social Security Number ____ _	19.	Date of Hire _____ Month Day Year (YYYY)		
15.	Date of Birth _____	20.	Experience on this job/equipment: <input type="checkbox"/> Under 3 months <input type="checkbox"/> 3 to 12 months <input type="checkbox"/> Over 12 months		
16.	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male				
If Property Damage or Vehicle Accident, Go to Line 27					
Injury/Illness (OSHA Information)					
21.	<input type="checkbox"/> Injury Code (10) <u>Illness Codes</u> <input type="checkbox"/> Code 7a(21) – Skin disease or disorders <input type="checkbox"/> Code 7b(22) – Dust diseases of lungs <input type="checkbox"/> Code 7c(23) – Resp. due to toxic agents <input type="checkbox"/> Code 7d(24) – Poisoning <input type="checkbox"/> Code 7e(25) – Disorders-Physical agents <input type="checkbox"/> Code 7f(26) – Disorders-Repeated trauma <input type="checkbox"/> Code 7g(29) – All others	24.	Has employee returned to work with no further anticipated workdays lost or restricted? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		25.	Permanent transfer to different job because of accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Terminated because of accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		
22.	Workdays Lost _____ (Actual if available or estimated expected)	26.	Did employee die? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", enter date _____ Month Day Year (YYYY)		
23.	Workdays Restricted _____ (Actual if available or estimated expected)				

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Property/Vehicle Damage																																												
27.	Property Loss Type (Select One) <table style="width:100%; border: none;"> <tr> <td style="width:20%;">Fire/Smoke:</td> <td><input type="checkbox"/> Building</td> <td><input type="checkbox"/> Brush</td> <td><input type="checkbox"/> Vehicle</td> <td><input type="checkbox"/> Other</td> <td></td> </tr> <tr> <td>Electrical:</td> <td><input type="checkbox"/> Equipment Contact</td> <td><input type="checkbox"/> Wiring <input type="checkbox"/> Grounding</td> <td><input type="checkbox"/> Overload <input type="checkbox"/> Other</td> <td><input type="checkbox"/> Insulation</td> <td><input type="checkbox"/> Polarity</td> </tr> <tr> <td>Explosion:</td> <td><input type="checkbox"/> Vapor</td> <td><input type="checkbox"/> Chemical</td> <td><input type="checkbox"/> Fluids</td> <td><input type="checkbox"/> High Explosives</td> <td><input type="checkbox"/> Dust</td> </tr> <tr> <td>Mechanical:</td> <td><input type="checkbox"/> Linear Energy <input type="checkbox"/> Overload</td> <td><input type="checkbox"/> Rotational Energy</td> <td><input type="checkbox"/> Pressure</td> <td><input type="checkbox"/> Falls</td> <td><input type="checkbox"/> Mechanical Breakdown</td> </tr> <tr> <td>Acts of Nature</td> <td><input type="checkbox"/> Wind <input type="checkbox"/> Earthquake</td> <td><input type="checkbox"/> Rain/Hail <input type="checkbox"/> Other</td> <td><input type="checkbox"/> Flood</td> <td><input type="checkbox"/> Freezing/Snow</td> <td><input type="checkbox"/> Lightning</td> </tr> <tr> <td>Leaks, Spills, Releases, or Contamination:</td> <td><input type="checkbox"/> Chemical</td> <td><input type="checkbox"/> Nuclear</td> <td><input type="checkbox"/> Environmental Impairment</td> <td colspan="2"><input type="checkbox"/> Other</td> </tr> <tr> <td>Miscellaneous:</td> <td><input type="checkbox"/> Thermal</td> <td><input type="checkbox"/> Corrosion</td> <td><input type="checkbox"/> Water Damage</td> <td><input type="checkbox"/> Sabotage</td> <td><input type="checkbox"/> Other</td> </tr> </table>		Fire/Smoke:	<input type="checkbox"/> Building	<input type="checkbox"/> Brush	<input type="checkbox"/> Vehicle	<input type="checkbox"/> Other		Electrical:	<input type="checkbox"/> Equipment Contact	<input type="checkbox"/> Wiring <input type="checkbox"/> Grounding	<input type="checkbox"/> Overload <input type="checkbox"/> Other	<input type="checkbox"/> Insulation	<input type="checkbox"/> Polarity	Explosion:	<input type="checkbox"/> Vapor	<input type="checkbox"/> Chemical	<input type="checkbox"/> Fluids	<input type="checkbox"/> High Explosives	<input type="checkbox"/> Dust	Mechanical:	<input type="checkbox"/> Linear Energy <input type="checkbox"/> Overload	<input type="checkbox"/> Rotational Energy	<input type="checkbox"/> Pressure	<input type="checkbox"/> Falls	<input type="checkbox"/> Mechanical Breakdown	Acts of Nature	<input type="checkbox"/> Wind <input type="checkbox"/> Earthquake	<input type="checkbox"/> Rain/Hail <input type="checkbox"/> Other	<input type="checkbox"/> Flood	<input type="checkbox"/> Freezing/Snow	<input type="checkbox"/> Lightning	Leaks, Spills, Releases, or Contamination:	<input type="checkbox"/> Chemical	<input type="checkbox"/> Nuclear	<input type="checkbox"/> Environmental Impairment	<input type="checkbox"/> Other		Miscellaneous:	<input type="checkbox"/> Thermal	<input type="checkbox"/> Corrosion	<input type="checkbox"/> Water Damage	<input type="checkbox"/> Sabotage	<input type="checkbox"/> Other
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(If Property Damage Accident go to Line 30)																																												
28.	Vehicle Type (Select One) <table style="width:100%; border: none;"> <tr> <td style="width:20%;">Light Highway</td> <td><input type="checkbox"/> Automobile</td> <td><input type="checkbox"/> Van</td> <td><input type="checkbox"/> Pickup truck</td> <td><input type="checkbox"/> Motorcycle, moped</td> <td><input type="checkbox"/> Highway vehicle, n.e.c.</td> </tr> <tr> <td>Heavy Highway:</td> <td><input type="checkbox"/> Bus</td> <td><input type="checkbox"/> Delivery truck</td> <td><input type="checkbox"/> Dump truck</td> <td><input type="checkbox"/> Semi-trailer, tractor trailer, trailer truck</td> <td><input type="checkbox"/> Truck, n.e.c. (e.g., fire truck)</td> </tr> <tr> <td>Air Rotary Wing</td> <td><input type="checkbox"/> Helicopter</td> <td colspan="4"><input type="checkbox"/> Aircraft--rotary wing, n.e.c.</td> </tr> <tr> <td>Air Fixed Wing</td> <td><input type="checkbox"/> Jet</td> <td><input type="checkbox"/> Propeller--driven aircraft</td> <td colspan="3"><input type="checkbox"/> Aircraft fixed wing, n.e.c.</td> </tr> <tr> <td>Other Vehicles</td> <td><input type="checkbox"/> Railroad</td> <td colspan="4"><input type="checkbox"/> Marine</td> </tr> </table>		Light Highway	<input type="checkbox"/> Automobile	<input type="checkbox"/> Van	<input type="checkbox"/> Pickup truck	<input type="checkbox"/> Motorcycle, moped	<input type="checkbox"/> Highway vehicle, n.e.c.	Heavy Highway:	<input type="checkbox"/> Bus	<input type="checkbox"/> Delivery truck	<input type="checkbox"/> Dump truck	<input type="checkbox"/> Semi-trailer, tractor trailer, trailer truck	<input type="checkbox"/> Truck, n.e.c. (e.g., fire truck)	Air Rotary Wing	<input type="checkbox"/> Helicopter	<input type="checkbox"/> Aircraft--rotary wing, n.e.c.				Air Fixed Wing	<input type="checkbox"/> Jet	<input type="checkbox"/> Propeller--driven aircraft	<input type="checkbox"/> Aircraft fixed wing, n.e.c.			Other Vehicles	<input type="checkbox"/> Railroad	<input type="checkbox"/> Marine															
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29.	Was vehicle equipped with seatbelts? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," was seatbelt in use? <input type="checkbox"/> Yes <input type="checkbox"/> No																																											
30.	Did vehicle accident involve recordable injury? <input type="checkbox"/> Yes <input type="checkbox"/> No																																											
31.	<table style="width:100%; border: none;"> <tr> <td style="width:30%;">Total Accident Damage</td> <td style="width:10%;">\$</td> <td style="width:60%; border-bottom: 1px solid black;"></td> </tr> <tr> <td>DOE Property/Vehicle</td> <td>\$</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td>Non- DOE Property/Vehicle</td> <td>\$</td> <td style="border-bottom: 1px solid black;"></td> </tr> </table>		Total Accident Damage	\$		DOE Property/Vehicle	\$		Non- DOE Property/Vehicle	\$																																		
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Equipment/Hardware/Vehicle Involved (as applicable)																																												
34.	<table style="width:100%; border: none;"> <tr> <td style="width:10%;">#1 Equipment</td> <td style="width:90%; border-bottom: 1px solid black;"></td> </tr> <tr> <td></td> <td style="border-bottom: 1px solid black;">Generic (or brand) name and model</td> </tr> <tr> <td>#2 Equipment</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td></td> <td style="border-bottom: 1px solid black;">Generic (or brand) name and model</td> </tr> </table>		#1 Equipment			Generic (or brand) name and model	#2 Equipment			Generic (or brand) name and model																																		
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35.	Did equipment design or defect contribute to accident cause or severity? <input type="checkbox"/> Yes <input type="checkbox"/> No	
NARRATIVE GUIDE		
DO NOT INCLUDE THE NAME (OR OTHER PERSONAL IDENTIFIER) OF THE EMPLOYEE/OPERATOR OR WITNESS IN THIS SECTION. Use third person references, e.g., he slipped on the wet floor and broke his right toe.		
36.	<u>Activity</u> in progress at time of accident. Be specific. For example, if the employee was using, equipment or handling materials or chemicals, name them and tell what he was doing with them. _____	
37.	<u>Events</u> Describe the accident sequentially, beginning with initiating events. Tell what happened, how it happened and end with nature and extent of injury/damage. Use a separate sheet for additional space. _____ Name any objects or substances (e.g., utility knife, glass beaker containing saline solution) involved and tell how they were involved. _____ Describe the nature of the injury/illness/damage. Name the body part affected if injury or illness. (e.g., amputation of right index finger at second joint). _____ Name and address of primary health care provider (e.g., physician, nurse, etc.) _____ If hospitalized overnight, name and address of hospital _____	
38.	Accident Causes a. Conditions _____ b. Actions _____ c. Factors influencing a or b. _____	
39.	Corrective Actions (If risk is acceptable, corrective action may not be necessary. If so, indicate "Not applicable" in section "a." below. a. Actions taken _____ b. Actions recommended _____ c. To be completed by _____ Implementation Date _____	
40.	Report Prepared by _____ Date _____ Telephone _____ Official Position: <input type="checkbox"/> Supervisor <input type="checkbox"/> Safety Professional <input type="checkbox"/> Other _____	
41.	Supervisor responsible for Corrective Action _____ Date _____ Telephone _____	
42.	Accident Investigation Contact (if different from line 40) _____ Telephone _____	